State of Michigan
Special Bulletin:

Medicare Plus Blue Group and You

Vol. 1, 2008

State Health Plan PPO members have a new retiree plan… Medicare Plus Blue Group℠

BCBSM's new plan, Medicare Plus Blue Group, simplifies health care for Medicare eligible retired employees:

- You have one ID card instead of two.
- You have one Explanation of Benefits instead of two.
- You have access to the large array of BlueHealthConnection® health programs that help people stay well, assist people with chronic conditions make the most of their health and provide valuable support to seriously ill or injured members.
- You don't need referrals to see a specialist.
- You can continue to go to any doctor, specialist or hospital who is willing to provide care and accepts Medicare and Medicare Plus Blue Group's terms and conditions for payment.

For more information, please call the Medicare Plus Blue Group Customer Service. You may call the toll-free line at 888-322-5557 (TTY 800-579-0235), Monday through Friday, 8:30 a.m. to 5 p.m.

We have answers for your questions!

Here is some additional information that reiterates plan essentials and answers questions you may have regarding Medicare Plus Blue Group coverage. If you have further questions, please call Medicare Plus Blue Group Customer Service at 888-322-5557, Monday through Friday, 8:30 a.m. to 5 p.m. TTY 800-579-0235.

What is Medicare Plus Blue Group?

Medicare Plus Blue Group is Blue Cross Blue Shield of Michigan's Medicare Advantage plan that will replace the State Health Plan PPO for retirees on Jan. 1, 2008. BCBSM will administer both Medicare and the State Health Plan as a single combined Medicare Advantage plan.

If you're Medicare-eligible, have Medicare Parts A and B, and are currently in the State Health Plan PPO, you'll automatically be enrolled in Medicare Plus Blue Group.

If you're not eligible for Medicare until after Jan. 1, 2008, you'll automatically be enrolled in Medicare Plus Blue Group when you become eligible.

How do I know I'm eligible for Medicare Plus Blue Group?

You're eligible for Medicare Plus Blue Group plan if you're:

- A resident of the U.S. for at least six months of the year
- Enrolled in Medicare Part A and Part B

What happens if I have not enrolled in Medicare Parts A and B?

Members who aren't eligible for Medicare Parts A and B (i.e., State Troopers) will continue to be covered under the State Health Plan PPO.

If you don't enroll in both Part A and Part B of Medicare when eligible, your health plan coverage will be adjusted as if Medicare coverage were in place. In this case, the plan will not reimburse that portion of an expense normally covered by Medicare. This may result in limited payment or no payment, or retroactive adjustment to claims.

What happens if I become eligible for Medicare after Jan. 1?

If you become eligible for Medicare after Jan. 1, 2008, it's important that you're enrolled in Medicare Parts A and Part B coverage in order to continue State Health Plan coverage under the Medicare Plus Blue Group plan. Once you have Medicare Part B coverage, we'll send you a pre-enrollment packet.

Do I have to change doctors?

You may continue to use any health care provider who accepts and participates with Medicare and accepts the Medicare Plus Blue Group's terms and conditions of payment.

Can I opt-out of BCBSM's Medicare Plus Blue Group plan?

Yes. There is an opt-out form that you must complete and return to BCBSM if you want to decline this coverage. Call Medicare Plus Blue Group Customer Service at 888-322-5557 to request an opt-out form.

While you or a Medicare-eligible dependent on your contract can choose not to participate in BCBSM's Medicare Plus Blue Group, you should consider the following consequences of losing your Blue Cross Blue Shield of Michigan coverage:

- You **will not** have health benefits covered by the State Health Plan.
- You **will not** have prescription drug coverage through the state Health Plan.

- You **will not** have mental health or substance abuse coverage through the State Health Plan.
- You'll **only be covered** by Original Medicare.

Please note: If you, as contract holder, decide not to enroll in the Medicare Advantage plan, everyone on your health care contract (all of your Medicare-eligible dependents, even those covered under the State Health Plan) will also be removed.

What costs will I be responsible for if I enroll in BCBSM's Medicare Plus Blue Group plan?

You'll continue to be responsible for the Medicare Part B premium, which is automatically deducted from your social security check. You will also be responsible for your deductible and coinsurance or copay amounts.

What's the difference between the State Health Plan and Medicare Plus Blue Group?

While Medicare Plus Blue Group covers the same services as the State Health Plan PPO, the method of calculating your deductible is different. (See page 4 for examples.)

Also, some of your copayments have changed. For example, under the State Health Plan, office visits copays are **up to** $10; however, under Medicare Plus Blue Group, your copay **is** $10.

It's important to remember that all Medicare Plus Blue services are administered according to Medicare guidelines. This may affect such services as annual mammograms. In this case, there are no age restrictions under the State Health Plan. However, because Medicare Plus Blue Group follows Medicare guidelines, annual mammograms are covered for members age 40 and older.

What's the difference between Original Medicare and Medicare Plus Blue Group?

Medicare Plus Blue Group covers more benefits than Original Medicare, including routine physical exams, additional immunizations, blood, chiropractic office visits, X-rays, private duty nursing, hearing exams and hearing aids — just to name a few.

Moreover, Original Medicare services that are covered after the deductible at 80 percent are, in most cases, covered by Medicare Plus Blue Group, at 90 percent or 100 percent after the deductible is paid.

How will Medicare Plus Blue Group affect my other benefits?

The Medicare Plus Blue Group plan doesn't include prescription drug, dental or vision benefits. You'll continue to access these benefits using your Express Scripts or Delta Dental ID card depending on the benefit. If you're enrolled in the Medicare Plus Blue Group plan, your mental health and substance abuse benefits through this plan will be administered by BCBSM instead of Magellan.

What happens if I am eligible for Medicare, but my spouse isn't?

In this case, you'll be covered under Medicare Plus Blue Group. Your spouse who is not eligible for Medicare will continue to be covered under the State Health Plan PPO.

Can I also be covered through Medicare Plus Blue Group and my spouse's Medicare Advantage plan?

No. You can only be covered under one Medicare Advantage plan at a time.

How do I handle my coverage if I'm out-of-state?

The Medicare Plus Blue Group coverage for Medicare-eligible members living out-of-state is the same for the Medicare-eligible living in-state. Members living out-of-state should still seek services from providers who participate with Medicare and are willing to accept the Medicare Plus Blue Group terms and conditions for payment. Always make sure to show your Medicare Plus Blue Group ID card each time you visit a doctor's office or hospital.

Does Medicare Plus Blue Group cover services outside of the U.S.?

Urgent and emergency care is covered for members traveling outside the U.S. Providers are usually paid by members when services are rendered. Send the receipt to Medicare Plus Blue Group and we'll reimburse you for the urgent or emergency care.

How does the Medicare Plus Blue Group's deductible differ from the State Health Plan PPO?

Under the State Health Plan, your annual deductible for 2008 is $200 per member and $400 per family. Under the Medicare Plus Blue Group plan, there is no family deductible. There is a $200 per member deductible. Here are a few scenarios to show you how the deductible under Medicare Plus Blue Group would apply:

Both retiree and spouse have Medicare Plus Blue Group. The retiree's deductible is $200 and the spouse's deductible is $200. The total deductible is $400.

The retiree has Medicare Plus Blue Group. The spouse has the State Health Plan PPO.
The retiree's deductible is $200 and the spouse's deductible is $200. The total deductible is $400.

Both the retiree and the spouse have Medicare Plus Blue Group. A (dependent) child is covered under the State Health Plan PPO.
The retiree's and spouse's deductible is $200 each. The deductible for the one dependent is $200. That's a total of $600 for the deductible.

Both the retiree and spouse have Medicare Plus Blue Group. There are three additional dependents that are covered under the State Health Plan PPO.
The retiree's deductible is $200 and the spouse's deductible is $200. The three dependents are covered as family, which has a $400 deductible. The total is $800 for the deductible.

Do I have to go to a network provider?

There are no network restrictions, and referrals aren't needed for specialists as long as your provider participates and accepts Medicare and BCBSM's Medicare Advantage plan, Medicare Plus Blue Group.

Once I am enrolled in Medicare Plus Blue Group, which card do I use?

Put your red, white and blue Medicare card with your social security number on it away for safe keeping. Instead, use your Medicare Plus Blue Group card that has a de-identified contract number, for all your health care services.

Will I receive a Medicare Plus Blue Group benefit booklet similar to the one for the State Health Plan PPO?

When you enroll, you'll receive an Evidence of Coverage document. This booklet will give you the details about your Medicare health coverage and explains how to get the care you need. The Evidence of Coverage should be used as an addendum to your benefit book, *Your Benefit Guide*.

More about Medicare Plus Blue Group benefits

With Medicare Plus Blue Group, you'll continue to receive the same covered services you received in your supplemental plan.

Because Original Medicare and BCBSM have combined benefits, you'll notice a few differences in the way your benefits are administered. Some of the differences that you'll notice are:

- There are no family deductibles and family out-of-pocket maximums for Medicare Advantage members. Each person has his or her own deductible to satisfy.
- Dependents who aren't eligible for Medicare will have separate BCBSM ID cards and will continue to have both individual/family deductibles and out-of-pocket maximums. They will continue to be covered as they are today.
- Your coinsurance amount is 10 percent on some services and is applied based on the Medicare-approved amount.
- There are no provider networks in Medicare Plus Blue Group. You may see any provider who accepts and participates with Medicare and agrees to accept the terms and conditions of Medicare Plus Blue Group's payment and policies.

What is a Medicare Advantage private fee for service plan?

Medicare Advantage plans are health plans that are approved by Medicare and administered by private companies. Medicare Advantage plans provide all of your Part A (hospital) and Part B (medical) coverage and must cover medically necessary services. They are also combined with the State Health Plan PPO coverage and may offer extra benefits over and above Original Medicare.

A Medicare Advantage private-fee-for-service plan allows you to see any doctor willing to provide service and accept the plan and Medicare's payment. Referrals aren't needed to see a specialist. And there are no network restrictions.

Medicare definitions you should know...

Original Medicare

The federal health insurance program for people 65 years of age and older, some people under age 65 with disabilities, and people with end-stage renal disease. Original Medicare has two parts: Part A (hospital insurance) and Part B (medical insurance).

Part A

Medicare Part A helps cover your inpatient care in hospitals. That care can be provided in a hospital, critical access hospital or a skilled nursing facility. Most people don't pay a premium for Part A because they or a spouse already paid for it through their payroll taxes while working.

Part B

Medicare Part B helps cover medical services like doctors' services, outpatient care and other medical services that Part A doesn't cover. Part B is optional. Part B helps pay for covered medical services and items when they are medically necessary. Part B also covers some preventive services. Most people pay a monthly premium for Part B.

Approved amount

The lower of the provider's billed charge or the Medicare maximum payment amount, whichever is lower.

Coinsurance

The amount you may be required to pay for services after you pay any plan deductibles. This is a percentage (%). You have to pay this amount after you pay the deductible.

Coordination of benefits

Applies when a member is covered by more than one health plan, to maximize coverage without duplicating payments. One plan is designated as primary for liability. Additional plans may cover remaining balances on the claim.

Copayment

The amount you pay for each medical service, like a doctor's visit. A copayment is usually a set amount you pay. Example: $10.

Deductible

The amount you must pay out-of-pocket for health care services, before your insurance begins to pay. A type of cost sharing in which the individual pays a specified amount for covered services before the health plan pays benefits.

Dependent

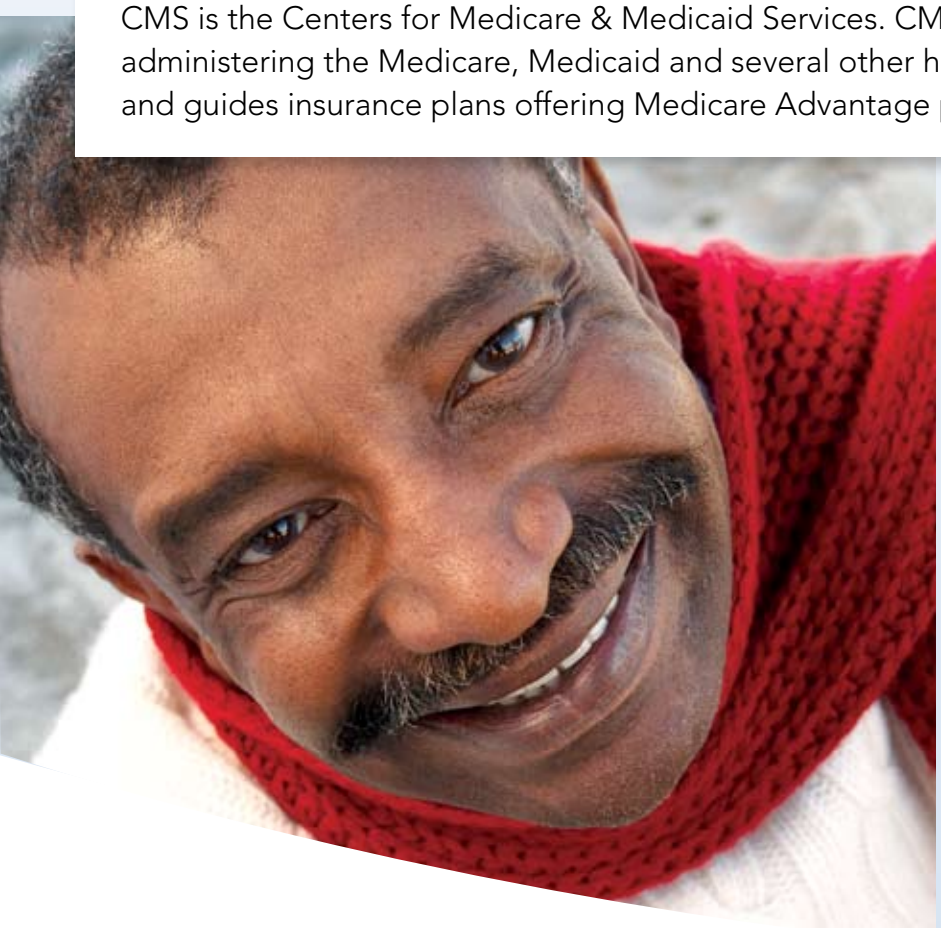
A person who is eligible for health care coverage on another individual's contract (most often this includes children eligible for coverage on their parent's contract).

Medically necessary

Services or supplies that are medically needed for the diagnosis or treatment of your medical condition. Must meet the standards of good medical practice and consistent with Medicare guidelines.

CMS

CMS is the Centers for Medicare & Medicaid Services. CMS is the agency responsible for administering the Medicare, Medicaid and several other health-related programs. CMS regulates and guides insurance plans offering Medicare Advantage plans.



A Medicare Advantage private fee-for-service plan works differently than a Medicare supplement plan. Your doctor or hospital must agree to accept the plan's terms and conditions prior to providing health care services to you, with the exception of emergencies. If your doctor or hospital does not agree to accept our payment terms and conditions, they may not provide health care services to you, except in emergencies. Providers can find the plan's terms and conditions on our Web site at bcbsm.com/ma.

Medicare PLUS Blue Group℠

Blue Cross Blue Shield of Michigan

Blue Cross Blue Shield of Michigan contracts with the federal government and is a nonprofit corporation and independent licensee of the Blue Cross and Blue Shield Association.

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